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|  | **ASTHMA MANAGEMENT FORM** |
| To help ensure the safety of your son / daughter it is essential that if they have any asthma condition that this form is completed accurately and with as much detail as possible. All information will remain confidential to teachers and any relevant care and response personnel. |
| **PLEASE PRINT ALL DETAILS** |
| NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOCTORS PHONE No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. What may trigger an asthma reaction? (food, Exercise, Cold Weather, Pollen, Animal Fur etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **2. What are the participant’s usual symptoms of asthma?** |
| Wheezing [ ]  | Difficulty in breathing [ ]  |
| Tightness in chest [ ]  | Coughing [ ]  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please complete the usual asthma management plan Below:**  |
| **Medication** | **Dosage**(e.g. 4 puffs) | **Method**(e.g. puffer & spacer) | **How often?**(e.g. every 4 mins) |
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| Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3. What are the participant’s signs/ symptoms of worsening asthma?** |
| Please Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **4. How severe is the participant’s asthma?** |
| Participant requires asthma medication most weeks of the year | Yes [ ]  | No [ ]  |
| Participant wakes regularly at night with asthma | Yes [ ]  | No [ ]  |
| Participant has required urgent medical attention for asthma in the last year | Yes [ ]  | No [ ]  |
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| 5. Is there anything else we should know about participant’s asthma condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Important Notes** |
| * It is advised that you consult your doctor before attending camp.
* Your doctor may contact the teacher in charge of the camp at your school and/or Kinchant Outdoor Education Centre (49541426).
* A letter from this person’s doctor outlining the participant’s asthma management **may** accompany this form when it is returned. Included in the asthma management plan **could** be the following:

o Preventative steps to avoid asthma reaction.o Warning signs for the onset of a severe asthma attack. o Best strategies for obtaining relief.* Programs conducted at Kinchant OEC involve a high level of physical activity and are conducted predominantly out of doors.
* Kinchant OEC is a 30 minute drive from the nearest ambulance, doctor or hospital and, in some instances, the response time for medical attention may exceed 2 hours.
* Kinchant Outdoor Education Centre teachers carry Ventolin in their first aid kits and are trained to an intermediate first aid level.
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| I declare that the information provided on this form is complete and correct |
| PARENT/ GUARDIAN’s SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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